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Division of Medical Services
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TO: **Arkansas Medicaid Health Care Providers - Physician/Independent Lab/CRNA/Radiation Therapy Center**

DATE: **February 1, 2005**

SUBJECT: **PROPOSED - Provider Manual Update Transmittal #93**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
229.100	10-13-03	229.100 – 229.130	2-1-05
DMS-671	1-2005	DMS-671	2-2005

Explanation of Updates

Section 229.100 has been revised to include new instructions for requesting benefit extensions. Effective February 1, 2005, extension requests must be sent to Arkansas Foundation for Medical Care, Inc. (AFMC).

Sections 229.110 through 229.130 have been added to the manual to provide instructions for completing the request for extension, documentation requirements and information regarding reconsideration of benefit extension denials. A copy of the revised Form DMS-671, "Request for Extension Of Benefits For Clinical, Outpatient, Laboratory and X-Ray Services", is attached.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

229.100 Extension of Benefits for Laboratory and X-Ray, Physician Office and Outpatient Hospital Services 2-1-05

A. Requests for extension of benefits for laboratory and x-ray, physician and outpatient services must be mailed to Arkansas Foundation for Medical Care, Inc. (AFMC), Attention EOB Review. **View or print the Arkansas Foundation for Medical Care, Inc. contact information.** Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.

Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. *Do not* send a claim.

B. A request for extension of benefits must be received by AFMC within 90 calendar days of the date of benefits-exhausted denial. Requests received after the 90-day deadline will not be considered.

C. AFMC will consider extending benefits in cases of medical necessity if *all* required documentation is received timely.

229.110 Completion of Request Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services" 2-1-05

A. Requests for extension of benefits must be submitted to AFMC for consideration. Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-ray Services (form DMS-671). **View or print form DMS-671.**

B. If the provider of service is a member of a provider group, the performing provider's number and the group provider number must be entered in the Medicaid provider ID number fields.

C. The provider's signature (with his or her credentials) and the date of the request are required on the form. Stamped or electronic signatures are accepted.

D. Claims for reimbursement must be filed in chronological order. Dates of service *must* be listed in chronological order on form DMS-671. When requesting benefit extension for more than four procedures, use a separate form for each set of four procedures.

E. Enter a valid type of service code using the applicable type of service code for paper claim(s). Some procedure codes require modifiers on paper claims

F. Enter a valid diagnosis code and brief narrative description of the diagnosis.

G. Enter a valid procedure code and, if applicable, modifier(s) along with a brief narrative description of the procedure.

H. Enter the number of units requested under the extension.

229.120 Documentation Requirements 2-1-05

A. To request extension of benefits for any benefit limited service, all applicable records that support the medical necessity of extended benefits are required.

B. Documentation requirements are as follows.

1. Clinical records *must:*

a. Be legible and include records supporting the specific request

b. Be signed by the performing provider

c. Include clinical, outpatient and/or emergency room records for dates of service in chronological order

d. Include related diabetic and blood pressure flow sheets

e. Include current medication list for date of service

f. Include obstetrical record related to current pregnancy

g. Include clinical indication for laboratory and x-ray services ordered with a copy of orders for laboratory and x-ray services signed by the physician

2. Laboratory and radiology reports *must* include*:*

a. Clinical indication for laboratory and x-ray services ordered

b. Signed orders for laboratory and radiology services

c. Results signed by performing provider

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests

229.130 Reconsideration of Extensions of Benefits Denial 2-1-05

A. Any reconsideration request for denial of extension of benefits must be received at AFMC within 30 days of the date of denial notice. When requesting reconsideration of denial, the following information is required:

1. Return a copy of current NOTICE OF ACTION denial letter with re-submissions.

2. Return all previously submitted documentation with additional information for reconsideration.

B. Only one reconsideration is allowed. Any reconsideration request that does not include required documentation will be automatically denied.

C. AFMC reserves the right to request further clinical documentation as deemed necessary to complete medical review.

REQUEST FOR EXTENSION OF BENEFITS FOR CLINICAL, OUTPATIENT, LABORATORY AND X-RAY SERVICES

Arkansas Foundation for Medical Care, Inc.
Attn: EOB Review
P O Box 180001
Fort Smith, AR 72918-0001

DATE: ____/____/____

Important: If all required information is not completed, the form will be returned to provider.

(1) **PERFORMING PROVIDER**	(2) **PROVIDER ID#** __ __ __ __ __ __ __ __ __
(3) **MAILING ADDRESS**	(4) **GROUP PROVIDER ID #** __ __ __ __ __ __ __ __ __
CITY **STATE** **ZIP CODE**	
(5) **PERFORMING PROVIDER SIGNATURE & CREDENTIALS**	

(6) **RECIPIENT NAME [LAST]** **[FIRST]** **[M.I.]**		
(7) **ADDRESS**	**CITY** **STATE**	**ZIP CODE**
(8) **MEDICAID RECIPIENT ID** (10 digits) __ __ __ __ __ __ __ __ __ __	(9) **DOB MM/DD/YY** ____/____/_____	**SEX** _____

To file a Request for Extension of Benefits, the following information is required:

(10) SERVICE FROM DATE	(11) SERVICE TO DATE	(12) TYPE OF SERVICE	(13) DIAGNOSIS CODE	(14) DIAGNOSIS CODE DESCRIPTION	(15) PROCEDURE CODE	(16) PROCEDURE CODE DESCRIPTION	(17) UNITS	**Request Disposition** *Completed By AFMC* DECISION APPROVED	DECISION DENIED	DATE OF REVIEW

Benefit Extension Control # _____ **Reviewer _____**
Completed by AFMC **Completed by AFMC**

When filing claim use the control number above to indicate the benefit extension is authorized.

Note: Attach copies of Medical Records/Supporting Documentation substantiating **medical necessity** of requested services/procedures.
[Instructions for requesting extension of benefits and completion of this form are included on the reverse side of this form.]
Comments:

Requirements for Requests for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services

Procedural Policy

To reduce delays in processing requests and to avoid returning requests due to incomplete and/or lack of documentation, the following procedures must be followed.

I. Requests for extension of benefits will be considered after a claim has been denied for exceeding the benefit limit.

II. The Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services (Form DMS-671) must be filed within 90 calendar days of the date of denial. Any request filed beyond the 90 calendar day deadline will be denied.

III. Extension of benefits will be denied if the original claim was denied for untimely filing (12 months beyond the date of service).

IV. AFMC EOB Review will consider extending benefits if ***all*** of the following documentation is received with request.

A. All fields of form DMS-671 must be correctly completed by entering the following information:

(1) Enter performing provider's name.
(2) Enter the Medicaid provider # of performing provider.
(3) Enter the address provider will use to receive correspondence regarding this extension.
(4) If the provider is a member of a group, enter the group provider ID #.
(5) Performing provider's signature and credentials must be entered in this field.
(6) Enter the recipient's full name.
(7) Enter the recipient's complete address.
(8) Enter the recipient's Medicaid ID #.
(9) Enter the recipient's date of birth and sex.
(10) Enter the service from date.
(11) Enter the service to date.
(12) Enter the type of service code (if claim was filed on paper).
(13) Enter the diagnosis code.
(14) Enter the diagnosis code description.
(15) Enter the procedure code and applicable modifier(s). (If there are more than 4 procedures, additional procedures must be added to a separate completed form.)
(16) Enter the procedure code description.
(17) Enter the number of units.

B. Copy of the Medical Assistance Remittance and Status Report stating benefits are exhausted for date of service. Do not send the claim form.

C. Clinical records must:

1. Be legible and include records supporting the specific request
2. Be signed by the performing provider
3. Include clinical, outpatient and/or emergency room records for dates of service in chronological order
4. Include related diabetic and blood pressure flow sheets
5. Include current medication list for date of service
6. Include obstetrical record related to current pregnancy

D. Laboratory and radiology reports must include:

1. Clinical indication for lab and x-ray ordered
2. Signed orders for laboratory and radiology
3. Results signed by performing provider
4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests

E. The Arkansas Medicaid Program automatically extends benefits when one of the following diagnoses exists and is entered as the primary diagnosis in both header and detail fields:

1. Malignant neoplasm (code range 140.0 – 208.91)
2. HIV, including AIDS (code 42)
3. Renal failure (code range 584 – 586)

F. Requests for reconsideration must be received within 30 calendar days of AFMC denial. Only one reconsideration will be allowed.

G. AFMC reserves the right to request further clinical documentation as deemed necessary to complete medical review.